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2013]

TREATING A CHRONIC CASE OF DISCRIMINATION: THE NINTH
CIRCUIT'S PRESCRIPTION FOR MENTAL HEALTH
PATIENTS' RIGHTS IN *HARLICK v.*
BLUE SHIELD

MEGAN LAGRECA*

“In a society where millions must hide debilitating diseases for fear of prejudice, where potentially life-saving health care is routinely denied to a disfavored class, where states have policies requiring parents to give up custody of mentally ill children as a condition of treating them, there are plenty of opportunities to strike a blow for justice. At the heart of this cause is ‘mental health parity’ legislation to end health insurance discrimination against those with mental illness.”¹

I. PREEXISTING CONDITIONS: MENTAL HEALTH COVERAGE IN THE
AMERICAN HEALTH CARE SYSTEM

In June 1999, Anna Westin was diagnosed with anorexia.² At the time of her diagnosis, Anna weighed eighty-two pounds, had an abnormal echocardiogram, a malfunctioning liver, and a below normal body temperature.³ Anna’s doctor ordered hospitalization, but told the Westins they would need their insurance company to certify the treatment.⁴ Anna’s mother thought “it was just a matter of a phone call.”⁵ Anna’s insurance company paid for a two-day hospital stay, then informed Anna that “her treatment was no longer medically necessary[,] and they would not pay any additional costs.”⁶ Unable to receive treatment, Anna Westin contin-

* Villanova University School of Law, J.D. Candidate 2014. This Note is dedicated to the memories of Joseph and Helen Lagreca, who taught me the importance of hard work and perseverance. None of this would have been possible without the support of my friends and family, especially John and Barbara Smith, who continue to teach me the importance of having strength in one’s convictions. Lastly, I would like to thank the editorial staff of the *Villanova Law Review*, especially Megan Pownall and Kathleen Dapper, whose insights and comments were integral to the completion of this article.

1. Patrick J. Kennedy, *Why We Must End Insurance Discrimination Against Mental Health Care*, 41 HARV. J. ON LEGIS. 363, 364 (2004) (footnote omitted).

2. See Kitty Westin, *When Your Child Dies of an Eating Disorder: A Mother’s Story*, EATING DISORDERS COALITION (June 13, 2002), <http://www.eatingdisorderscoalition.org/congbriefings/061302/housebriefing061302.html#westin> (recounting story of daughter’s anorexia before Congress).

3. See *id.* (describing medical complications from anorexia nervosa).

4. See *id.* (detailing conflicts with insurance company over coverage of anorexia treatment).

5. *Id.*

6. *Id.*

ued to suffer from anorexia and ultimately committed suicide at her home on February 17, 2000, when she was twenty-one years old.⁷

Almost two thousand miles away in San Mateo, California, Jeanene Harlick had been suffering from anorexia for over twenty years.⁸ In 2006, Jeanene checked into Castlewood Treatment Center in St. Louis, Missouri.⁹ At the time of her admission, she was thirty-five percent below her ideal body weight and had to use a feeding tube to receive vital nutrients.¹⁰ When Blue Shield of California refused to cover her treatment at Castlewood, Jeanene's parents borrowed hundreds of thousands of dollars against their home to pay for the treatment.¹¹ After suing Blue Shield in district court, the Ninth Circuit held in a landmark ruling that California's Mental Health Parity Act ("Parity Act") required insurance companies to cover medically necessary treatments for severe mental illnesses even if the plan excluded such coverage.¹²

This Note argues that the Ninth Circuit's interpretation of the Parity Act correctly addresses the case-specific needs of mental health patients and allows physicians to pursue all medically necessary treatment without a concern that the patient's insurance company may deny such care.¹³ Part II provides an overview of mental health parity legislation since the introduction of managed care organizations into the American health care system, focusing on the federal system's early statutory framework.¹⁴ Part III examines the history and text of the Parity Act, and discusses the state and federal courts' interpretations of it.¹⁵ Part IV discusses the facts of the Ninth Circuit's recent decision in *Harlick v. Blue Shield of California*¹⁶ and

7. See *id.* (testifying to Congress on family struggles with anorexia).

8. See Andrew Pollack, *Eating Disorders a New Front in Insurance Fight*, N.Y. TIMES, Oct. 14, 2011, at A1 (discussing legal battles arising from insurance companies' denials of residential treatment for anorexia).

9. See *id.* (providing background of Jeanene Harlick's claims against insurance company).

10. *Id.* (explaining Harlick's medical status at time of admission to residential treatment center).

11. See *id.* (acknowledging financial hardships caused by expenses of residential treatment when coverage is denied by insurers).

12. See *Harlick v. Blue Shield of Cal.*, 686 F.3d 699, 719 (9th Cir. 2012) (holding that all non-exempt California insurance plans must cover medically necessary treatments for severe mental illnesses even if plan excluded such coverage).

13. See Victoria Colliver, *Eating-Disorder Patients Battle Insurers Over Care*, S.F. CHRON. (Sept. 10, 2011), <http://www.sfgate.com/news/article/Eating-disorder-patients-battle-insurers-over-care-2310184.php> (interviewing doctor who remarked that, "[H]is patients have to be 'literally on the verge of death' to get hospitalized and then their insurance coverage often dictates how much care or what kind of care comes next").

14. For a discussion of mental health coverage in employee health benefit plans, see *infra* notes 20–54 and accompanying text.

15. For a discussion of the Parity Act and lower federal courts' interpretations prior to the Ninth Circuit's holding, see *infra* notes 55–96 and accompanying text.

16. 686 F.3d 699 (9th Cir. 2012).

the court's application of the Parity Act.¹⁷ Part V analyzes the Ninth Circuit's reasoning and argues that *Harlick* successfully shifted the dialogue from one of stringent parity to a broader, more flexible definition of parity that remains sensitive to the case-specific needs of mental health patients.¹⁸ Finally, Part VI discusses implications of the Ninth Circuit's holding for patients who, like Jeanene Harlick, are denied medically necessary treatment.¹⁹

II. PLACING PARITY IN CONTEXT: FEDERAL APPROACHES TO MENTAL HEALTH PARITY

The stories of Anna Westin's denial of care or the Harlicks' crippling debt demonstrate the failure of a health care system that, despite federal mental health parity reform, allowed insurance companies to deny or limit medically necessary treatment to mental health patients.²⁰ This section provides a brief overview of the complex health care system that the Westins and Harlicks navigated in order to receive treatment for their daughters.²¹ As denials of care for mental health patients continued to rise in the 1990s, so did the saliency of mental health parity, which resulted in two stages of federal mental health parity reform.²² This section explains the genesis of that legislation and its failure to comprehensively address the needs of mental health patients.²³

A. Mental Health Care Under Managed Care Settings

Today, most Americans obtain health care coverage through the workplace.²⁴ Most private insurers under employee benefit plans have his-

17. For a discussion of the majority opinion's rationale and holding, see *infra* notes 97–144 and accompanying text.

18. For a discussion on how the Ninth Circuit's holding has shifted the parity framework from one of statutory interpretation to an individualized patient-centered analysis, see *infra* notes 145–74 and accompanying text.

19. For conclusions about the impact of the Ninth Circuit's holding on future mental health parity cases, see *infra* notes 175–95 and accompanying text.

20. See Stacey A. Tovino, *All Illnesses Are (Not) Created Equal: Reforming Federal Mental Health Insurance Law*, 49 HARV. J. ON LEGIS. 1, 6 (2012) (noting that, even after passage of two pieces of federal mental health parity legislation, “[p]rivate health insurers . . . have a long history of providing less comprehensive insurance benefits to individuals with mental illness”).

21. See Westin, *supra* note 2 (describing confusion of insurance company's denial letters and their recommendation of treatment “without ever meeting Anna or understanding her particular case”).

22. See Tovino, *supra* note 20, at 6 (describing federal attempts at achieving mental health parity).

23. See *id.* at 6–7 (“Notwithstanding the efforts of mental health parity advocates, neither the federal Mental Health Parity Act of 1996 (“MHPA”) nor the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”) required private insurers to offer insurance benefits for mental illness.” (footnotes omitted)).

24. See DEP'T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 419 (1999) [hereinafter SURGEON GENERAL REPORT] (finding

torically limited mental health benefits due to fear of “high costs associated with long-term and intensive psychotherapy and extended hospital stays.”²⁵ In an effort to limit these benefits, insurers increased deductibles, reduced the number of annual outpatient visits, and lowered the lifetime or annual limits on mental health care.²⁶

As a reaction to the rising health care costs of the 1970s and 1980s, many employers switched their health benefits to a managed care setting.²⁷ Through methods of cost containment, many managed care organizations were able to obtain mental health benefits at “relative equality” with physical health benefits.²⁸ Still, as the managed care organizations’ share of the employee benefit market expanded and health costs rose, such organizations freely increased deductibles, reduced outpatient or inpatient visits, and decreased lifetime or annual limits on care.²⁹

These annual limits and increased out-of-pocket costs have become particularly detrimental for mental illnesses such as anorexia nervosa, both in terms of the treatment’s duration and cost.³⁰ As in the case of

that eighty-four percent of Americans receive health benefits through employee benefit plans, and that fifty-six percent of Americans are enrolled in managed care organizations).

25. *Id.* at 418. Insurance companies justified limiting mental health coverage by citing the health economic principles of moral hazard and adverse selection. *See* Tovino, *supra* note 20, at 9–10 (explaining impact of moral hazard and adverse selection on mental health coverage). Tovino explains that “[i]n the context of mental health care, moral hazard refers to the concern that individuals who do not pay for 100% of the cost of their own mental health care will use more mental health services because they do not value these services at their full cost.” *Id.* In addition, adverse selection reflects the concern that, if a plan offers “generous mental health benefits,” it “will attract individuals with greater mental health care needs” *Id.* at 11.

26. *See* Tovino, *supra* note 20, at 9–11 (explaining measures taken by insurance companies to limit mental health care coverage).

27. *See* Aviv Shamash, Note, *A Piecemeal, Step-By-Step Approach Toward Mental Health Parity*, 7 J. HEALTH & BIOMEDICAL L. 273, 277 (2011) (discussing mental health parity in context of growing popularity of managed care organizations); SURGEON GENERAL REPORT, *supra* note 24, at 422. According to the Surgeon General Report, fifty-six percent of Americans were covered under some type of managed care organization by 1999. *See id.* (emphasizing importance of managed care organizations in providing mental health care). Unlike traditional private insurance, managed care organizations use various financial incentives to control costs. *See id.* at 423 (analyzing managed care organizations’ cost-control methods). For example, most managed care organizations shift inpatient treatment to an outpatient setting, negotiate discounted hospital and doctor’s fees, and use a utilization review process to certify a patient’s treatment to decide whether such treatment is necessary. *See id.* (enumerating examples of cost-cutting strategies used by managed care organizations).

28. *See* Shamash, *supra* note 27, at 277.

29. *See id.* (explaining how popularity of managed care organizations led to lower quality mental health care).

30. *See* Beth A. Brunalli, Note, *Anorexia Killed Her, But the System Failed Her: Does the American Insurance System Suffer From Anorexia?*, 12 CONN. INS. L.J. 583, 597–99 (2006) (discussing effects of insurance industry’s limitations on mental health care in context of anorexia). Anorexia, like most mental illnesses, deals with “complex

Jeanene Harlick, a patient faces a losing choice when insurance companies cap mental health benefits.³¹ The patient's family must incur debt to help the patient complete the treatment, or the patient must stop treatment before achieving their ideal body weight and risk relapsing.³²

B. *Federal and State Legislative Impetus: The Federal Mental Health Parity Act of 1996*

In the 1990s, federal and state legislatures began to consider mental health parity legislation in order to equalize the disparity between physical and mental health coverage.³³ One commentator has argued that the legislative movement toward mental health parity was the product of three factors.³⁴ First, developments in medical research shifted the dialogue around mental illness from one of stigmatization to one of understanding, as new research revealed biological bases for these illnesses.³⁵ Second, as

biopsychosocial issues" that require an integrated approach to treatment, including "medical, nutritional, and mental health professionals." *Id.* at 589–91. As such, anorexia patients often require a more intense care regiment for a longer period of time. *See id.* at 595 (comparing insurance company's coverage plan with clinical guidelines on treatment of anorexia). Applying the American Psychiatric Association guidelines to most insurance companies' restrictions on hospital stays, Brunalli stated that "restoration of ideal body weight . . . cannot be achieved in ten to fifteen days unless the patient's ideal body weight is forty pounds." *Id.* at 595 n.86. Insurance companies' limitations of mental health coverage do not only inhibit the duration of treatment that a patient may need, but they also imposes prohibitive costs on patients. *See id.* at 596 ("[T]he patient or the patient's parents must finance on average \$80,000 of care, which is nearly two-thirds of the cost of treatment, per incident of the disorder.").

31. *See id.* at 597 (noting that anorexia is "[a] perpetuating cycle of illness" because insurance companies' coverage limitations frustrate complete treatment).

32. *See id.* ("Not surprisingly, the rate of relapse or readmission has more than doubled since the proliferation of mental illness limitations.").

33. *See* Dana L. Kaplan, Note, *Can Legislation Alone Solve America's Mental Health Dilemma? Current Legislative Schemes Cannot Achieve Mental Health Parity*, 8 QUINNIPIAC HEALTH L.J. 325, 328 (2005) (discussing emergence of mental health parity legislation).

34. *See id.* at 328–29 (discussing factors leading to passage of parity legislation). For a full discussion of these factors, see *infra* notes 35–37 and accompanying text.

35. *See* Kaplan, *supra* note 33, at 328 (enumerating factors that led to influx of mental health parity legislation in 1990s). The clinical community uses two main classification systems to define mental illness. *See* Marcia C. Peck & Richard M. Scheffler, *An Analysis of the Definitions of Mental Illness Used in State Parity Laws*, 53 PSYCHIATRIC SERVICES 1089, 1089–90 (2002), available at <http://ps.psychiatryonline.org/data/Journals/PSS/4351/1089.pdf> (finding that definitions of mental health in state parity laws can influence access, cost, and insurance reimbursement). The first classification comes from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders ("DSM"). *See id.* (explaining different clinical classification systems for mental illnesses). The DSM defines mental illness as a "clinically significant behavioral or psychological syndrome or pattern that occurs in an individual, . . . is associated with present distress . . . or disability . . . or with a significant increased risk of suffering." *Id.* (alterations in original). The second main classification views mental illnesses as brain disorders,

a result of these new findings, mental health advocacy rose in the 1990s.³⁶ Lastly, the passage of the federal Mental Health Parity Act of 1996 (“MHPA”) influenced states to create their own mental health parity legislation.³⁷

Although the MHPA spurred state legislators to consider their own mental health parity legislation, the effect of the MHPA remained negligible.³⁸ Rather than mandate mental health coverage on an equal basis among all insurers, the MHPA only regulated insurers who already pro-

and is built on premise that “disruptions in brain function lead to mental illness.” *Id.* Clinicians view this second classification as “too limiting, because no single gene or underlying brain lesion has been found for any disorder except Alzheimer’s disease.” *Id.* Despite its criticism, this second classification is used by biopsychiatrists who define mental illness by heredity or genetic makeup. *See id.* (describing use of classification systems by clinicians). Despite the differing classifications in the clinical community, both definitions of mental illness suggest that the bases of such disorders “are now considered physical, or biological, rather than ‘mental.’” Richard E. Gardner, Comment, *Mind Over Matter? The Historical Search for Meaningful Parity Between Mental and Physical Health Care Coverage*, 49 EMORY L.J. 675, 683 (2000) (discussing how advances in brain science show biological components to mental illnesses). For example, researchers have found that in the brains of those patients who suffer from major depression, there is a decrease in neural activity. *Id.* at 684. In addition, panic disorders are now thought to have a biochemical basis because of patients’ positive responses to chemical treatments, like antidepressants. *Id.* at 685.

36. *See* Kaplan, *supra* note 33, at 329 (noting that as of 2005, there were over 360 organizations that support mental health parity). Support for mental health parity legislation expanded beyond professional organizations to include federal legislators. *See* Melissa M. McGow, Comment, *A Plan for Recovery: Steps to Finally Provide Adequate Insurance Coverage for Those Starving for it the Most*, 15 ROGER WILLIAMS U. L. REV. 583, 607–09 (2010) (discussing federal support for comprehensive federal parity statute). Representative Patrick Kennedy of Rhode Island, who suffered from periods of depression, remarked that federal parity legislation was “one more step in the long civil rights struggle to ensure that all Americans have the opportunity to reach their potential.” *Id.* at 609. Representative Kennedy’s father, the late United States Senator Edward Kennedy, also remarked that insurance companies’ limitations on mental health benefits were “senseless discrimination.” *Id.* at 606.

37. *See* Kaplan, *supra* note 33, at 329 (discussing impetus of federal and state mental health parity statutes). Before 1996, only five states had adopted mental health parity laws: Maryland, New Hampshire, Rhode Island, Maine, and Minnesota. *See* Peck & Scheffler, *supra* note 35, at 1089–90 (analyzing different classification systems and their incorporation into early state parity laws). After the MHPA was passed, twenty-nine states passed parity bills with stronger provisions than the MHPA. *See id.* (describing rise of state parity laws as reaction to federal parity legislation). As of December 2011, forty-eight states had passed mental health parity laws, though the type of mandate varied. *See* Richard Cauchi, Steven Landess & Andrew Thangasamy, *State Laws Mandating or Regulating Mental Health Benefits*, NAT’L CONFERENCE OF STATE LEGISLATORS, <http://www.ncsl.org/issues-research/health/mental-health-benefits-state-laws-mandating-or-re.aspx> (last updated Dec. 2012) (surveying all states’ steps towards achieving mental health parity). Only Michigan and Pennsylvania had not passed mental health parity laws by December 2011, but both states require insurers to cover substance abuse treatment. *Id.*

38. *See, e.g.*, Tovino, *supra* note 20, at 35–38 (discussing “incomplete development” of mental health parity laws on federal level).

vided mental health coverage.³⁹ While this minimal mandate isolated many insurance plans from the law's effects, two additional exemptions limited the law's impact.⁴⁰ Small employers were entirely exempt from the MHPA's requirements.⁴¹ Moreover, group health plans were exempt from the law's requirements if compliance with the MHPA increased the costs under the plan.⁴²

In addition to these exemptions, Congress's failure to define "mental health benefits" within the MHPA contributed to the law's inefficacy, as it gave insurance companies the discretion to define and limit the range of mental illnesses that it would cover.⁴³ Eating disorders, for example, were not expressly mentioned in the MHPA.⁴⁴ Congress's failure to close this discretionary gap was most likely a political decision, as one study has found that legislators' decisions to define mental illness are influenced by "ideologies of advocacy groups and parity opponents, cost, and political necessity," rather than "needs-based studies and clinical judgment."⁴⁵

C. *A Second Federal Attempt at Achieving Mental Health Parity*

In 2008, President Bush signed into law the Mental Health Parity and Addiction Equity Act ("MHPAEA"), which addressed the continuing issue

39. See 29 U.S.C. § 1185a(1),(2) (2006) (stating that MHPA only regulates lifetime and annual spending limits of those insurance plans that cover both physical and mental health benefits).

40. See McGow, *supra* note 36, at 588–94 (discussing limitations of MHPA).

41. See Mental Health Parity Act of 1996, Pub. L. No. 104-204, § 712(c)(1)(A), 110 Stat 2874, 2944 ("This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of a small employer."). Further, the MHPA defined a small employer as one "who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year." *Id.* § 712(c)(1)(B).

42. See *id.* § 712(c)(2) ("This section shall not apply with respect to a group health plan . . . if the application of this section to such plan . . . results in an increase in the cost under the plan . . . of at least 1 percent.").

43. See *id.* § 712(e)(4) ("'[M]ental health benefits' means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency."); Shamash, *supra* note 27, at 282 (discussing limitations of MHPA).

44. See McGow, *supra* note 36, at 592 ("Although the MHPA did not exclude eating disorders from the list of mental illnesses, it also did not explicitly include them; rather, the employer was allowed to define what constitutes mental illnesses and easily excluded eating disorders.").

45. Peck & Scheffler, *supra* note 35, at 1091. The authors of the study noted that while federal legislation has not defined mental illness to date, the term's use in federal legislation has nevertheless been interpreted "to include all disorders in DSM [Diagnostic and Statistical Manual of Mental Disorders]." *Id.* at 1090. For a full discussion of the two main classifications of mental illness among the clinical community, see *supra* note 35.

of disparate mental health coverage by private insurers.⁴⁶ The MHPAEA was more comprehensive than the MHPA because it expanded the MHPA's mandate to include substance use disorders.⁴⁷ Moreover, the MHPAEA broadly prohibited insurance companies from imposing unequal financial or coverage restrictions on mental health care.⁴⁸ This language extended beyond the MHPA, which only prohibited the imposition of disparate annual and lifetime limits.⁴⁹ In addition, insurers could not place more restrictive limitations on mental health beneficiaries in terms of deductibles, copayments, coinsurance, out-of-pocket expenses, number of doctor's visits, or days of coverage.⁵⁰

Although the MHPAEA was more comprehensive than the MHPA, the law suffered similar setbacks in terms of its limited scope.⁵¹ Much like the MHPA, exemptions for small employers and group health plans that would experience cost increases severely limited the law's reach.⁵² Moreover, the law's mandating power extended only to those insurance plans that already covered mental health benefits.⁵³ Under the MHPAEA, it was possible that insurers could choose not to cover mental health benefits and remain exempt from federal mental health parity legislation entirely.⁵⁴

46. See Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 29 U.S.C. § 1185a(a)-(g) (2006) (requiring non-exempt insurance companies to provide equal mental health and physical health services).

47. See *id.* § 1185a(a)(1)(A) ("If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health or substance use disorder benefits.").

48. See *id.* § 1185a(a)(3)(A)(i)-(ii) (stating that group health plans that cover both medical and mental health benefits must ensure that financial requirements and treatment limitations are no more restrictive than predominant limitations placed on medical care).

49. See *id.* § 1185a(a)(1)(A)-(B), (2)(A)-(B) (barring imposition of lifetime or annual limits for health plans that offer medical and surgical benefits, as well as mental health and substance abuse benefits).

50. See *id.* § 1185a(a)(3)(B)(i) (defining scope of what constitutes financial requirement under MHPAEA).

51. See Tovino, *supra* note 20, at 38 (discussing limitations of MHPAEA, as compared to MHPA).

52. See *id.* ("MHPAEA . . . did not apply to small group health plans, individual health plans, the Medicare Program, Medicaid non-managed care plans, or any self-funded, non-federal governmental plans whose sponsor opted out of MHPAEA.").

53. See Shamash, *supra* note 27, at 278 (discussing differing levels of mandatory state parity laws). For a discussion on the varying levels of mandating power, see *infra* notes 61-67 and accompanying text.

54. See Tovino, *supra* note 20, at 38 ("In terms of its substantive provisions, MHPAEA also was neither a mandated offer nor a mandated benefit law; that is, nothing in the MHPAEA required a covered group health plan to actually offer or provide any mental health benefits.").

III. SEARCHING FOR A CURE: CALIFORNIA'S PARITY ACT

While federal legislation fails to provide a comprehensive framework for covering mental illnesses in the private insurance context, many state mental health parity laws require insurers to offer broader coverage for mental health benefits.⁵⁵ At issue in *Harlick* was California's Parity Act, which the California legislature passed in 1999.⁵⁶ The Parity Act sought to improve access to mental health care by requiring health insurance plans to provide equal coverage for physical and mental health illnesses.⁵⁷

A. Analyzing California's Parity Act

Four factors influence the comprehensiveness of state mental health parity laws.⁵⁸ First, the statutory definition of mental illness indicates the breadth of the parity law and can range from a "broad-based mental illness" to a narrow "serious mental illness" definition.⁵⁹ Although Califor-

55. See Shamash, *supra* note 27, at 287 (asserting that state parity laws are more comprehensive than federal parity laws).

56. See CAL. HEALTH & SAFETY CODE § 1374.72(d)(1)-(9) (West 2003) (requiring that all non-exempt insurers provide equal services for mental and physical health care).

57. See *id.* (stating goals of Parity Act); see also Lucas Quass, *Federal Efforts to Achieve Mental Health Parity: A Step in the Right Direction, but Discrimination Remains*, 4 LEGIS. & POL'Y BRIEF 35, 52 (2012), available at <http://digitalcommons.wcl.american.edu/lpb/vol4/iss1/2> (providing background information regarding passage of California's Parity Act).

58. See Shamash, *supra* note 27, at 287-88 (analyzing state parity laws' varying levels of mandating power).

59. See *id.* (explaining states' varying definitions of mental illness); see also Kaplan, *supra* note 33, at 351 (analyzing state mental health parity laws under a similar framework). A study conducted by the American Psychiatric Association determined that state mental health parity laws define mental illness in one of three ways: from the most comprehensive "broad-based mental illness" to the less encompassing "serious mental illness" or "biologically based mental illness." Peck & Scheffler, *supra* note 35, at 1090. Broad-based mental illness is defined by a "person's ability to function rather than his or her diagnosis." *Id.* at 1091. Many of the states whose parity laws are defined as "broad-based" cover all mental illnesses that are contained in the DSM. See *id.* (analyzing three definitions of mental illness that states have adopted for parity laws). For a full discussion of the DSM classification of mental illness, see *supra* note 30. Although state definitions vary for "serious mental illness," the definition does not include every mental illness contained in the DSM. See Quass, *supra* note 57, at 52 (discussing limitations of using "severe mental illness" definition in parity laws). State laws that use the term serious or severe mental illness typically only address those illnesses that are considered "priority populations." Peck & Scheffler, *supra* note 35, at 1091. These priority populations include those individuals diagnosed with schizophrenia, schizoaffective disorder, major depressive disorder, obsessive-compulsive disorder, panic disorder and other anxiety disorders, and attention-deficit hyperactive disorder. See *id.* (defining scope of mental illness to select priority populations). Only six states have defined mental illness as "biologically based": Massachusetts, Missouri, Virginia, New Jersey, Colorado, and South Dakota. See *id.* at 1093 (studying different states' adopted definitions of mental illness). The authors of the study noted that these states are "charting new territory because the term [biologically-based mental illness] has never been used in federal legislation and has no accepted clinical defi-

nia's Parity Act uses the word "severe mental illness," the statute's definition of "severe" encompasses the same priority populations that a "serious mental illness" definition addresses, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.⁶⁰

Second, the mandating structure that the legislature chooses also determines the comprehensiveness of a state mental health parity law.⁶¹ A mandatory benefit structure requires insurers to provide mental health benefits.⁶² Conversely, a mandatory offer structure only requires insurers to offer a plan with mental health benefits and to charge accordingly.⁶³ The weakest mandating structure is the mandated-if-offered framework, which requires insurers to provide mental health benefits to the same extent that they provide physical health care.⁶⁴ The Parity Act reads, "[e]very health care service plan contract . . . that provides hospital, medical, or surgical coverage *shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses* of a person of any age . . ."⁶⁵ The Parity Act, unlike federal parity laws, is a mandated benefit statute that requires all non-exempt insurers to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses.⁶⁶ As seen in *Harlick*, a state's chosen framework can lead to contentious litigation.⁶⁷

nition." *Id.* at 1091. For a discussion on the clinical community's criticisms of the "biologically-based" definition, see *supra* note 35.

60. See CAL. HEALTH & SAFETY CODE § 1374.72(d)(1)-(9) (West 2003) (defining scope of mental illnesses required by Parity Act). Though California's statute defines this list of mental illnesses as "severe," rather than "serious," the list is consistent with other states' definitions of "serious mental illness." See Peck & Schefler, *supra* note 35, at 1091 (discussing states' definitions of mental illnesses).

61. See Shamash, *supra* note 27, at 290 (analyzing how mandating structure of parity laws impact its comprehensiveness).

62. See Kaplan, *supra* note 33, at 351-53 (discussing mandatory benefit framework). Kaplan notes that common statutory language for a mandated benefit statute reads as follows: "a plan shall provide benefits for diagnosis and mental health treatment under the same terms and conditions as provided for covered benefits for the treatment of other physical illnesses." *Id.* at 351.

63. See *id.* at 352 (discussing mandatory offer framework for state parity laws). A mandated offer statute would typically read, "insurers must make available coverage for the treatment of mental illness . . ." *Id.* at 352.

64. See *id.* (defining various parity frameworks and their levels of mandating power). The language of a mandated-if-offered statute would read, "in the case of a group health plan that provides mental health benefits, those benefits must be provided on par with benefits for other physical illnesses . . ." *Id.*

65. CAL. HEALTH & SAFETY CODE § 1374.72(a) (West 2003) (emphasis added).

66. See *id.* (stating that all insurers must provide mental health coverage). For a discussion of the various mandating frameworks, see *supra* notes 61-65 and accompanying text.

67. See *id.* (requiring that all insurers are obligated to provide mental health coverage on parity with physical health coverage). As a mandated-benefit statute, the Parity Act requires insurers to provide coverage for "medically necessary treatment of severe mental illnesses," which includes the following: outpatient services, inpatient hospital services, partial hospital services, and prescription drugs, if the

Third, how state legislators choose to regulate the terms of insurance plans also dictates the statute's comprehensiveness.⁶⁸ The Parity Act regulates insurance plans by requiring that "[t]he terms and conditions applied to the benefits required by this section . . . shall be applied equally to all benefits under the plan contract."⁶⁹ However, the Parity Act only requires the following terms and conditions to be equal among mental health and physical health benefits: maximum lifetime limits, copayments, and individual and family deductibles.⁷⁰

Lastly, the exemptions contained in a state mental health parity law can easily frustrate its comprehensiveness.⁷¹ The largest exemption placed on state mental health parity laws is the Employee Retirement Income Security Act of 1974 ("ERISA").⁷² As a federal scheme that regulates

plan covers them. *Id.* § 1374.72(a), (b)(1)–(4). For definitions of these care settings, see *infra* note 106. Based on this mandated benefit language, the main issue in *Harlick* was whether the Parity Act required coverage of residential care, which required a preliminary analysis of whether subsection (b) of the Parity Act was an exhaustive list of treatments. See *Harlick v. Blue Shield of Cal.*, 686 F.3d 699, 712 (9th Cir. 2012). In addition, the Ninth Circuit also decided whether the Parity Act, under subsection (b) required coverage for all medically necessary treatments of the mental illnesses enumerated in subsection (d). See *id.* at 713–17 (interpreting Parity Act).

68. See Shamash, *supra* note 27, at 291 (analyzing how parity law's regulation of terms and conditions affects law's comprehensiveness).

69. CAL. HEALTH & SAFETY CODE § 1374.72(c)(1)–(3) (West 2003).

70. See *id.* (limiting applicable terms and conditions). The Parity Act does not regulate a plan's other terms and conditions, such as "out-of-pocket maximums, and inpatient and outpatient visitation maximums." See Shamash, *supra* note 27, at 291 (enumerating different terms and conditions that parity law may regulate). The provision may not be exhaustive however, as it uses the language "shall include, but not be limited to" when it lists the terms and conditions. CAL. HEALTH & SAFETY CODE § 1374.72(c) (West 2003). For a discussion on how the Ninth Circuit interpreted this same statutory language under subsection (b) of the Parity Act, see *infra* notes 117–21 and accompanying text.

71. See Shamash, *supra* note 27, at 291–92 (analyzing how federal legislation can exempt or preempt state parity laws and inhibit their efficacy). For a brief discussion of ERISA preemption in the context of state parity laws, see *infra* note 72.

72. 29 U.S.C. § 1002 (2006) (regulating state laws relating to employee benefit plans). ERISA broadly preempts any state law that relates to an employee benefit plan. See *id.* § 1144(a) (explaining statute's preemptions). An exception to this broad preemption lies in the "savings clause," which "saves" certain state laws from preemption, such as those laws regulating insurance. See *id.* § 1144(b)(2)(A). A state law is exempt from ERISA preemption if it is directed towards "entities engaged in insurance" and if the law "substantially affect[s] the risk pooling arrangement between the insurer and the insured." *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 342 (2003). The Tenth Circuit has upheld a district court's holding that ERISA does not preempt state parity laws. See *Douglas S. v. Altius Health Plans, Inc.*, 409 Fed. App'x 219, 222 n.3 (2010) (declining to review district court's finding that ERISA did not preempt state parity law because "neither party briefed this issue . . . and it [was] unnecessary to reach this issue to resolve this appeal"); see also *Z.D. ex rel. J.D. v. Grp. Health Coop.*, 829 F. Supp. 2d 1009, 1015 (W.D. Wash. 2011) (holding that ERISA did not preempt Washington's mental health parity law). Conversely, the Eighth Circuit has held that an additional ER-

employee health benefit plans, many state law parity claims are dismissed upon the threshold issue of whether ERISA preempts the parity law.⁷³

B. *Applying the Parity Act: Inconsistency in the Lower Federal and State Courts*

The patchwork approach that federal and state governments have taken towards parity legislation has hindered the efficacy of federal and state parity laws.⁷⁴ Despite advocacy efforts and court cases addressing the comprehensiveness of mental health parity laws, most state and federal parity laws remain riddled with exemptions and limited mandates.⁷⁵ The Ninth Circuit's ruling finally provides an example of a comprehensive state parity regime that places the patient, rather than the insurance company, at the center of the parity analysis.⁷⁶

Since the passage of the Parity Act, both lower federal and California state courts have grappled with interpreting the law, and more specifically, the subsection that specifies what modalities of treatment are to be provided on an equal basis.⁷⁷ In *Harlick*, the Ninth Circuit addressed whether the list of mandated services in subsection (b) of the Parity Act was exhaus-

ISA provision, the "deemer clause," continues to exempt some employee benefit plans from state mental health parity laws. See *Daley v. Marriott Int'l, Inc.*, 415 F.3d 889, 894–95 (8th Cir. 2005) (holding that "self-funded ERISA plans are exempt from state regulation insofar as that regulation 'relate[s] to' the plans" (alteration in original)). The circuit courts' disagreement regarding whether state parity laws are exempted by the savings clause or deemer clause is beyond the scope of this Casenote. For a further discussion on how ERISA interacts with state parity legislation, see Quass, *supra* note 57, at 55–56.

73. See *Daley*, 415 F.3d at 894–95 ("[S]elf-funded ERISA plans are exempt from state regulation insofar as that regulation 'relate[s] to' the plans." (alteration in original)). For a discussion of the current circuit split and other federal courts' holdings on the threshold issue of ERISA preemption and state parity laws, see *supra* note 72.

74. See Shamash, *supra* note 27, at 301–06 (discussing how federal and state mental health parity laws interact).

75. See Tovino, *supra* note 20, at 38–39 (comparing exemptions in MHPA and MHPAEA); see also Shamash, *supra* note 27, at 292–93 (analyzing federal limitations on state parity acts).

76. See *California's Mental Health Parity Act Requires Health Plan to Cover "Medically Necessary" Residential Treatment for Anorexia Nervosa*, CAL. INS. L. & REG. REP. (THOMPSON WEST), July 2012, at 4 [hereinafter *Parity Act Requires "Medically Necessary" Coverage*] ("California's Mental Health Parity Act requires insurers and health care plans subject to the Act to provide medically necessary treatment for eating disorders, even if its policy specifically excludes such treatment.").

77. See CAL. HEALTH & SAFETY CODE § 1374.72(b)(1)–(4) (West 2003) ("These benefits shall include the following: (1) outpatient services, (2) inpatient hospital services, (3) partial hospital services, [and] (4) prescription drugs, if the plan contract includes coverage for prescription drugs."). The Department of Managed Health Care ("DMHC") was charged with promulgating the regulation that would enforce the Parity Act. See *Harlick*, 686 F.3d at 712 ("[T]he California Department of Managed Health Care . . . promulgated a regulation implementing the Parity Act in 2003."). For a discussion of this regulation and the Ninth Circuit's interpretation, see *infra* notes 128–30 and accompanying text.

tive.⁷⁸ If so, the subsection would only mandate parity in outpatient services, inpatient hospital services, partial hospital services, and prescription drugs under certain plans.⁷⁹

In *Wayne W. v. Blue Cross of California*,⁸⁰ the district court for the District of Utah held that the Parity Act “does not, on its face, require Blue Cross to provide benefits for stays at a residential treatment center on the same basis as other medical benefits.”⁸¹ Although Utah has its own mental health parity law, the district court interpreted California’s Parity Act because the plaintiff was a beneficiary of his father’s benefit plan, which was provided by Blue Cross of California.⁸² In its interpretation of California’s Parity Act, the court reasoned that interpreting subsection (b) of the Parity Act as an exhaustive list “comports with general rules of statutory construction.”⁸³ Moreover, the court noted that interpreting the Parity Act any other way would violate the intent of the Department of Managed Health Care (“DMHC”).⁸⁴

The DMHC’s administrative history leading to the promulgation of the Parity Act’s accompanying regulations became the crux of the Northern District of California’s rationale in *Daniel F. v. Blue Shield of Califor-*

78. See *Harlick*, 686 F.3d at 712 (stating that court would hear issue of whether residential care was required by Parity Act because both parties requested ruling on that issue and because record was fully developed).

79. See *id.* (determining that if subsection was not exhaustive, Parity Act would only require parity in four modalities of treatment).

80. No. 1:07-CV-00035 PGC, 2007 WL 3243610, at *1 (D. Utah Nov. 1, 2007).

81. *Id.* at *3. The plaintiff in *Wayne* was a minor diagnosed with severe attention deficit hyperactivity disorder, mood disorder, substance abuse, and other high-risk behaviors. See *id.* at *1. The plaintiff was placed in a residential treatment center for adolescents, where he stayed for 371 days between 2004 and 2005. See *id.* Because Blue Cross’s contract placed an annual limit of one hundred days of treatment at such a facility, the plaintiff’s additional care was denied in 2005 when he exceeded his annual limit. See *id.* The plaintiff argued that, “Blue Cross’s application of the limitation on treatment at Island View violates California law, ERISA, and the Plan.” *Id.* at *2. The court found that, “[e]ven assuming for the sake of argument that the California parity statute at issue is saved from ERISA preemption,” the Parity Act did not require Blue Cross to provide residential treatment “on the same basis as other medical benefits.” *Id.* at *3.

82. *Id.* at *1 (explaining application of California Parity Act in Utah).

83. *Id.* at *4. In reaching this conclusion, the court reasoned that the non-exhaustive list in subsection (c) of the Parity Act implies that the absence of similar wording in subsection (b) “can only signify that the four specifically listed benefits are the only ones required by the law” *Id.*

84. See *id.* (emphasizing that DMHC’s intent was crucial to interpretation of Parity Act). The court cited to a 2005 DMHC study of California’s managed care plans, noting the agency’s findings, which stated that “[t]he coverage and use of RTCs [residential treatment centers] vary markedly among plans” *Id.* (alterations in original). The study justified such varied coverage by asserting that each of these managed care plans made a “policy decision.” *Id.* Thus, the court held that, in light of its statutory interpretation and the “DMHC’s characterization of the very limitation on residential treatment . . . as a ‘policy decision,’” the Parity Act did not require Blue Cross to cover residential treatment on the same level as other medical benefits. *Id.*

nia.⁸⁵ In *Daniel F.*, the district court adopted the *Wayne* court's interpretation of the Parity Act, and held that the insurance company's reading of subsection (b) was "reasonable and in good faith."⁸⁶ The court cited the DMHC's survey of managed care plans, which noted that a plan's limitation of treatment facilities is a "policy decision" that is left to the discretion of the insurance company.⁸⁷ While the court noted that the DMHC's reports do not "have the force and effect of law," the findings were nevertheless "relevant to the analysis of whether the Parity Act requires coverage for residential treatment."⁸⁸

The dicta in one California appellate court holding alluded to a broad interpretation of what the Parity Act deems "medically necessary."⁸⁹ In *Arce v. Kaiser Foundation Health Plan*,⁹⁰ the California Court of Appeals noted that a categorical denial of "coverage for mental health care services that may . . . be medically necessary" constitutes a violation of the Parity Act.⁹¹ The appellate court concluded that "the trial court too narrowly

85. No. C 09-2037 PJH, 2011 WL 830623, at *1 (N.D. Cal. Mar. 3, 2011) (holding that California legislators did not intend for Parity Act to cover all mental health services). In *Daniel F.*, the plaintiff's son was admitted to a wilderness therapy program after receiving "acute inpatient psychiatric treatment on several occasions." *Id.* Before his admission, Blue Shield informed the plaintiff that residential treatment was not a covered benefit. *See id.* Plaintiffs filed suit, arguing that Blue Shield's practice of excluding residential treatment violated the Parity Act. *See id.* at *2.

86. *Id.* at *7. The court referred to the plan's contract, noting that inpatient mental health services were covered, "but only when those services are provided at a 'Hospital' . . ." *Id.* Because the treatment facility was not accredited as a psychiatric hospital, or even a "psychiatric health care facility" under pertinent California law, Blue Shield did not err in rejecting coverage. *See id.* (reasoning that lack of accreditation under state law did not require Blue Shield to cover residential treatment).

87. *See id.* at *9 (deferring to insurance company in regards to mental health coverage). The court expanded its reasoning outside of the plan contract, looking to the administrative history of the DMHC's promulgation of the Parity Act's regulation, which cited a lack of residential care as a plan's "policy decision." *See id.* (citing administrative agency's previous research to justify limiting mental health coverage). Rather than adopting an expansive meaning of what constitutes "medically necessary treatment," the court interpreted the Parity Act to require "Blue Shield [to] provide[] benefits for mental health conditions on a par with those for other medical conditions, for outpatient services, inpatient hospital services, and partial hospital services." *Id.* at *8.

88. *Id.* at *9 (citing *Yamaha Corp. of Am. v. State Bd. of Equalization*, 960 P.2d 1031, 1036 (Cal. 1998)).

89. *Arce v. Kaiser Found. Health Plan*, 104 Cal. Rptr. 3d 545 (Ct. App. 2010) (holding that categorical denial of coverage also violates Parity Act).

90. 104 Cal. Rptr. 3d 545 (Ct. App. 2010).

91. *Id.* at 565. In *Arce*, the plaintiff was a four-year-old boy who was diagnosed with autism, and was a member of a Kaiser health plan that excluded "custodial care" from its coverage. *See id.* at 478-79 (describing plaintiff's mental health illness). The Kaiser plan defined custodial care as "assistance with activities of daily living, . . . or care that can be performed safely and effectively by people, who in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse." *Id.* at 479.

read the . . . protections of the Mental Health Parity Act.”⁹² Moreover, the appellate court corrected the trial court’s finding that the Parity Act required the plaintiff to prove why the treatment was medically necessary.⁹³ In doing so, the *Arce* court noted two ways in which an insurance company could violate the Parity Act.⁹⁴ The first and most widely acknowledged way of violating the Parity Act occurs when an insurance company wrongfully denies care that was medically necessary for the diagnosis or treatment of a severe mental illness.⁹⁵ In addition, the *Arce* court held that an insurance company’s failure to make the medically necessary inquiry at all constitutes a second means of violating the Parity Act.⁹⁶

IV. DIAGNOSING A SICK SYSTEM: THE NINTH CIRCUIT’S RULING IN *HARLICK V. BLUE SHIELD OF CALIFORNIA*

In *Harlick*, the Ninth Circuit addressed the scope of the Parity Act in deciding whether one of the Act’s subsections only required parity in limited modalities of treatment.⁹⁷ Though the court limited its analysis to residential treatment of anorexia nervosa, the majority broadly held that the Parity Act required coverage for the diagnosis and medically necessary treatment of all severe mental illnesses listed in the statute.⁹⁸ Such a holding is not only cognizant of the case-specific needs of mental health patients, but it also illustrates how judicial action can augment legislative

92. *Id.* at 565. The trial court reasoned that because the Parity Act only mandates “medically necessary treatment,” the plaintiff must prove that the therapies at issue were medically necessary in order to determine whether the Parity Act had been violated. *See id.* (determining that trial court erred in holding that plaintiff must prove whether treatment was medically necessary). The appellate court rejected this reasoning and noted that:

It is possible that *Arce* also could prove a statutory violation by showing that Kaiser categorically denies coverage for mental health care services that may, in some circumstances, be medically necessary, and that Kaiser does so without considering whether such services are in fact medically necessary for its individual plan members.

Id.

93. *See id.* (concluding that trial court “too narrowly read . . . the protections of the Mental Health Parity Act”).

94. *See id.* at 565–67 (establishing two-prong analysis for violations of Parity Act).

95. *See id.* at 565 (noting that denial of medically necessary treatment is “one means of establishing a violation [of] the statute,” but “not the exclusive means”).

96. *See id.* at 566 (stating that insurance company’s categorical denial of reviewing medically necessary inquiry constitutes violation of Parity Act). Unlike the district courts in *Wayne W.* and *Daniel F.*, the appellate court in *Arce* suggested that an insurer’s liability could be expanded to include occurrences when the company “never considers the issue of medical necessity because it has concluded that there is no coverage for these therapies in the first place.” *Id.* at 565.

97. *See Harlick v. Blue Shield of Cal.*, 686 F.3d 699, 712 (9th Cir. 2012).

98. *See id.* at 721 (reasoning that such interpretation was “common sense”).

efforts by providing states with a broad, regulatory scheme for mental health parity.⁹⁹

A. *Facts and Procedural History of Harlick*

Plaintiff Jeanene Harlick brought suit against Blue Shield of California (“Blue Shield”) after the insurer refused to cover her residential treatment for anorexia.¹⁰⁰ Harlick had been suffering from anorexia nervosa since she was about eighteen years old.¹⁰¹ When Harlick was thirty-eight years old, she relapsed and sought intensive outpatient treatment for her anorexia.¹⁰² This treatment was covered through Blue Shield, who was her employer’s health insurance provider.¹⁰³

As Harlick’s condition worsened, her doctor recommended a more intense course of treatment than the outpatient treatment that she had been receiving.¹⁰⁴ Blue Shield informed Harlick that, pursuant to her plan, only medically necessary “partial or inpatient (full-time) hospitalization” was covered.¹⁰⁵ Though Blue Shield referred Harlick to several facilities that were covered under her plan, her doctors “determined that none of the in-network facilities suggested by Blue Shield could provide effective treatment.”¹⁰⁶ As such, Harlick sought treatment at an out-of-network provider, the Castlewood Treatment Center, in Missouri.¹⁰⁷

99. *See id.* (holding that insurance companies were required to provide all medically necessary treatment for severe mental illnesses); *see also infra* note 172 (discussing other state courts’ mental health parity holdings). *But see* Tovino, *supra* note 20, at 2 (describing courts’ failure to effectively rule in favor of patients’ rights).

100. *See Harlick*, 686 F.3d at 706.

101. *See id.* at 703 (recounting plaintiff’s history of anorexia).

102. *See id.* (discussing plaintiff’s previous treatment of anorexia).

103. *See id.* (noting that Blue Shield had previously covered treatment of plaintiff’s anorexia).

104. *See id.* (describing Harlick’s worsening anorexia).

105. *Id.* (explaining denial of coverage).

106. *Id.* at 703–04.

107. *See id.* at 704 (describing Harlick’s new course of treatment). Castlewood’s care levels were at varying degrees of intensity, including: “a community support group, an outpatient program, an intensive outpatient program, day treatment, ‘Step Down’ or partial hospitalization, and residential care.” *Id.* Despite these varying methods of care, Castlewood’s website “consistently” classifies the facility as residential. *Id.* (discussing website and its information on residential treatment). For purposes of this Note, Blue Shield’s definitions for these methods of care will be used. Blue Shield defines an inpatient as “an individual who has been admitted to a Hospital or a Skilled Nursing Facility as a registered bed patient and is receiving Services under the direction of a Physician.” BLUE SHIELD OF CAL., SHIELD SAVER 4000: HEALTH PLAN FOR INDIVIDUALS AND FAMILIES, EVIDENCE OF COVERAGE AND HEALTH SERVICE AGREEMENT 69 (2012), available at https://www.blueshieldca.com/producer/download/public/ShieldSaver4000_7-12.pdf (defining types of care provided under basic Blue Shield plan). An outpatient facility is defined as “a licensed facility, not a Physician’s office or Hospital, that provides medical and/or surgical services on an Outpatient basis.” *Id.* at 65. An intensive outpatient care program is defined as “an Outpatient Mental Health (or substance

Blue Shield paid for Harlick's first eleven days of treatment at Castlewood, but refused to pay for the rest of her treatment.¹⁰⁸ Various internal documents showed that upon review by Blue Shield employees, Harlick's coverage was denied because the treatment facility "appear[ed] to be residential care as stated in the consent to treatment/treatment plan [and] [r]esidential treatment is not a benefit."¹⁰⁹ In her disputes with Blue Shield, Harlick received several inconsistent letters stating why coverage was denied.¹¹⁰ Though all of the letters from Blue Shield employees explained that residential treatment was not covered under her plan, other employees noted that Harlick needed to be authorized by the Mental Health Services Administrator to seek out-of-state treatment.¹¹¹ In corresponding with Harlick, employees also noted that the Parity Act did not require them to offer residential treatment because the plan did not cover residential care "whether the diagnosis [wa]s for a mental health condition or a medical condition."¹¹²

abuse) treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week." *Id.* at 69. Partial hospitalization is defined as a "treatment program that may be freestanding or Hospital-based and provides Services at least five (5) hours per day and at least four (4) days per week." *Id.* "Patients may be admitted directly to this level of care, or transferred from acute Inpatient care following acute stabilization." *Id.* Residential care is defined as "services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for Members who do not qualify for Acute Care or Skilled Nursing Services." *Id.* at 70.

108. *See Harlick*, 686 F.3d at 705 (recounting plaintiff's communications with Blue Shield). In their communication with Harlick, Blue Shield claimed that the first eleven days of coverage were due to a coding error. *See id.* at 708.

109. *Id.* at 704–05. Harlick's plan covered the following mental health services: inpatient services, limited outpatient services, office visits, psychological testing, and in-person and telephone counseling. *See id.* For physical illnesses, the plan covered "extensive hospital treatment," outpatient care, office visits, and subacute care. *See id.* (discussing coverage for physical illnesses).

110. *See id.* at 705–07 (recounting plaintiff's communications with Blue Shield). For a discussion of the communications between Harlick and Blue Shield during her appeals process, see *infra* notes 111–12 and accompanying text.

111. *See Harlick*, 686 F.3d at 705 (explaining plaintiff's communications with insurance company during internal reviews process). This was clarified in later letters, in which another employee explained that the preauthorization requirement did not apply to out-of-state facilities; *see also* *Thompkins v. BC Life & Health Ins. Co.*, 414 F. Supp. 2d 953, 960 (C.D. Cal. 2006) (holding that Parity Act "does not limit application of the parity law on the basis of where the *individual beneficiaries* live or seek medical care").

112. *Harlick*, 686 F.3d at 706. After citing a preauthorization requirement and the inapplicability of California's Parity Act, Blue Cross sent a final letter to Harlick that explained the ultimate reason for denial of coverage—her plan did not cover residential care. *See id.* (noting that plaintiff had exhausted Blue Shield's internal review process). Moreover, the letter explained that the first eleven days of her facility expenses were only paid because of a "coding error." *Id.* (noting error in payment). The medical coder used a billing code that "did not identify the claim as a mental health diagnosis," so the claim was paid. *Id.*

Harlick's mother appealed Blue Shield's coverage decision to the California Insurance Commissioner.¹¹³ After an investigation was conducted by the DMHC, the agency's senior counsel noted that, "although [Harlick] ha[d] been provided with conflicting information from the Plan regarding its basis for denial," Blue Shield had denied coverage because Harlick's plan did not cover residential care.¹¹⁴ Harlick brought suit against Blue Shield in the Northern District of California.¹¹⁵ The district court granted Blue Shield's motion for summary judgment, finding that "Harlick's Plan unambiguously excluded coverage for residential care."¹¹⁶ The court did not reach the question of whether the Parity Act required Blue Shield to cover Harlick's residential treatment.¹¹⁷

On August 26, 2011, a panel of three Ninth Circuit judges held that Blue Shield must provide coverage for a beneficiary's mental health treat-

113. *See id.* (explaining plaintiff's administrative appeals process through DMHC). In his investigation of Blue Shield's denial of Harlick's care, the California Insurance Commissioner inquired,

(1) [W]hy Harlick had been told that residential care was not medically necessary; (2) why Harlick was told that benefits would be denied because care was not pre-authorized, even though the Plan clearly stated that lack of preauthorization resulted only in a \$250 penalty; and (3) whether Castlewood could be covered as an SNF [skilled nursing facility].

Id.

Although the Insurance Commissioner's findings did not discuss why Castlewood could not be considered a skilled nursing facility, the Ninth Circuit alluded to this inquiry in its opinion. *See id.* at 704 (noting that Castlewood is consistently described as "residential" community on its website, and that none of its staff members are medical doctors or nurses).

114. *Id.* (alterations in original).

115. *See Harlick v. Blue Shield of Cal. Grp. Health Plan*, 2010 WL 760484, *5 (N.D. Cal. Mar. 4, 2010).

116. *Harlick*, 686 F.3d at 706 (describing district court's reasoning). The district court also held that Castlewood could not be considered a skilled nursing facility, which would have been covered under Harlick's plan. *See Harlick*, 2010 WL 760484, at *5 (analyzing plaintiff's claim that Castlewood was skilled nursing facility). In its reasoning, the district court noted that Blue Shield defines a skilled nursing facility as "a facility with a valid license issued by the California Department of Health Services as a Skilled Nursing Facility or any similar institution licensed under the laws of any other state, territory, or foreign country." *Id.* The district court looked to Missouri's definition of a skilled nursing facility. *See id.* (analyzing whether definition of skilled nursing facility could fall within Blue Shield's covered modalities of treatment). Because Missouri only defined skilled nursing facilities in terms of physical illnesses, the court held that "[i]f it is impossible for Castlewood to be licensed as a SNF in Missouri, then the Court cannot regard Castlewood as a SNF." *Id.* at *6. The court also noted that, despite Missouri's limited definition of a skilled nursing facility, Harlick also failed to present any evidence that Castlewood's professional staff included nurses. *See id.* (rejecting plaintiff's argument that Castlewood was skilled nursing facility for purpose of Blue Shield coverage).

117. *See Harlick*, 686 F.3d at 706 (reviewing issues resolved by district court). The district court reasoned that because Castlewood was not a skilled nursing facility, and thus did not involve any facet of Harlick's plan that was denied to her, "the Court d[id] not need to reach Plaintiff's argument that Harlick's plan violates the MHPA [Parity Act]." *Harlick*, 2010 WL 760484, at *6.

ment at a residential facility, despite the plan's explicit exclusion of residential treatment.¹¹⁸ Blue Shield petitioned the Ninth Circuit to set aside its decision, arguing that the panel misinterpreted the Parity Act to require all medically necessary services.¹¹⁹ The insurance company asserted that such a reading of the Parity Act is contradictory to California's Knox-Keene Act, which only requires insurers to cover basic services for physical illnesses.¹²⁰ The panel rejected Blue Shield's petition, but withdrew its opinion and issued a new opinion on June 4, 2012.¹²¹

B. *Majority Opinion*

The Ninth Circuit held that while residential care was not covered under Harlick's plan, California's Parity Act required Blue Shield to cover Harlick's residential care for her anorexia.¹²² The threshold issue concerned whether there was an abuse of discretion regarding the ERISA plan

118. See *Harlick v. Blue Shield of Cal.*, 656 F.3d 832, 849–50 (9th Cir. 2011) (“We therefore conclude that the most reasonable interpretation of the Parity Act . . . is that plans within the scope of the Act must provide coverage of all ‘medically necessary treatment’ for the nine enumerated ‘severe mental illnesses’ under the same financial terms as those applied to physical illnesses.”), *withdrawn and superseded*, 686 F.3d 699 (9th Cir. 2012).

119. See *Harlick*, 686 F.3d at 721 (Smith, J., dissenting in part and concurring in part) (discussing Blue Shield's petition for rehearing and petition for rehearing en banc). For a full discussion of Judge Smith's dissent, see *infra* note 144.

120. See *9th Circuit Upholds Landmark Mental Illness Coverage Ruling*; *Harlick v. Blue Shield of Cal.*, WESTLAW J. INS. COVERAGE (Thompson West) June 15, 2012, 2 (“Blue Shield petitioned for the full 9th Circuit to set aside the panel's ruling, arguing for the first time that the regulation[] . . . reference[s] California's Knox-Keene Act . . . [which] requires that insurers only cover basic services for physical illnesses, not all medically necessary services . . .”).

121. See *Harlick*, 686 F.3d at 703 (“This court's opinion filed on August 26, 2011 . . . is withdrawn and replaced by the attached Opinion and Dissent.”).

122. See *id.* at 721 (interpreting Parity Act as requiring coverage of all medically necessary treatment, even if specific treatment is not included in individual's plan). Harlick first claimed, pursuant to her plan's terms, that if Blue Shield refused to cover residential care, then Blue Shield should still have covered Harlick's stay at Castlewood as a “skilled nursing facility,” which was covered under Harlick's plan. See *id.* at 709 (reviewing plaintiff's arguments against Blue Shield). The court reasoned that because Castlewood did not have any medical staff, it could not qualify as a skilled nursing facility under California or Missouri law. See *id.* at 709–10 (analyzing whether definition of Castlewood fits within Blue Shield's coverage for skilled nursing facility). Harlick argued that because California's licensing laws included “similar institutions” under its skilled nursing facility category, Castlewood should be considered a “similar institution.” *Id.* at 709 (citing CAL. HEALTH & SAFETY CODE § 1250(c) (West 2000)). The court held that “the Plan covers SNFs in California, as well as institutions in other states that provide around-the-clock nursing care for physical illnesses, even if they are given a different name in those states.” *Id.* at 710. Because Castlewood lacked medical staff and was referred to as a residential facility on its website, the court concluded that Blue Shield did not abuse its discretion in finding that Castlewood was not a skilled nursing facility. See *id.*

administrator's decision to deny Harlick's benefits.¹²³ The court next ana-

123. *See id.* at 707 (discussing whether there was abuse of discretion in Blue Shield's decision to deny residential care). The Ninth Circuit began its analysis by determining "whether the plan explicitly grants the administrator discretion to interpret the plan's terms." *Id.* (citing *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 967 (9th Cir. 2006)). Here, both parties conceded that discretion was permitted under Harlick's plan, and the court thus proceeded to review the ERISA plan administrator's decision in denying Harlick's benefits. *See id.* at 707 (analyzing whether Blue Shield abused its discretion in denying care for Harlick's residential treatment at Castlewood). The majority opinion emphasized that their review would be "'tempered by skepticism' when the plan administrator has a conflict of interest in deciding whether to grant or deny benefits." *Id.* (quoting *Abatie*, 458 F.3d at 959). Such a conflict arises where, as in *Harlick*, the plan administrator both reviews coverage decisions and pays for the benefits. *See id.* (applying conflict of interest analysis to Blue Shield's denial of coverage).

The amount of skepticism placed on the plan administrator's decision differs based on the severity of the conflict. *See id.* (describing how various levels of skepticism are applied to insurance plan based on whether conflict of interest is found). For example, "[t]he conflict is less important when the administrator takes 'active steps to reduce potential bias and to promote accuracy,' such as using an 'independent review process,' or segregating employees who make coverage decisions from those who deal with the company's finances." *Id.* (citing *Abatie*, 458 F.3d at 969 n.7). Conversely, a conflict is taken more seriously if the plan has a history of bias, has given inconsistent reasons for denial of care, or has failed to fully review the denial claim. *See id.* (enumerating factors that led court to apply more skepticism to insurance company's denial of coverage).

Harlick asserted four reasons why the court should apply the skepticism analysis to Blue Shield's decision. *See id.* First, Blue Shield had a conflict of interest because the company made coverage decisions and paid for such coverage. *See id.* (stating plaintiff's first argument for ERISA abuse of discretion analysis). In addition, Blue Shield had offered inconsistent reasons for the denial of Harlick's care. *See id.* (considering plaintiff's second argument as to why higher level of skepticism applied to Blue Shield plan). Besides its inconsistent reasoning, Blue Shield also did not fully review Harlick's claims because the company did not offer a reason as to why the Parity Act did not apply. *See id.* (noting that Blue Shield's refusal to give concrete reason for denial weighed in favor of abuse of discretion). Lastly, Blue Shield excluded residential treatment from Harlick's plan but did not define what constituted residential treatment. *See id.* (concluding plaintiff's four arguments against Blue Shield in court's abuse of discretion analysis).

In its review of these four assertions, the court stated that the record did not indicate "whether Blue Shield has a history of bias in claims administration" *Id.* The court agreed with Harlick that Blue Shield's communications with her were "confusing and frustrating," though nothing indicated that the changed reasons of denial were done in bad faith. *See id.* at 708 (rejecting plaintiff's contention that Blue Shield's denial of coverage was due to bad faith). The court then rejected Harlick's claim that Blue Shield did not consider its compliance with the Parity Act, as one letter to Harlick stated that, "Blue Shield believed that the Act did not mandate coverage." *Id.* Lastly, the court reasoned that while Blue Shield did not define residential treatment, "there [wa]s no indication that Blue Shield exploited any uncertainty about the meaning of 'residential care.'" *Id.* Thus, the court found two reasons for tempering its review with skepticism: Blue Shield's "structural conflict," and the company's confusing communications with Harlick. *See id.* (weighing factors against Blue Shield in abuse of discretion analysis). The court concluded that, despite these reasons, there was no abuse of discretion and, based on Harlick's plan alone, residential treatment for anorexia was not required. *See id.* at 708 (holding that Harlick's plan did not require coverage for residential treatment).

lyzed whether the Parity Act required coverage of residential care, even if Blue Shield's plan did not explicitly offer it.¹²⁴ The court then expanded its inquiry, and analyzed whether the Parity Act required coverage for all medically necessary treatments of anorexia.¹²⁵ Finally, the court applied its findings and analyzed whether residential care was medically necessary for Harlick's treatment.¹²⁶

1. *Does the Parity Act Require Coverage of Residential Care?*

The Ninth Circuit noted that subsection (b) of the Parity Act states that benefits "shall include" outpatient services, inpatient hospital services, partial hospital services, and prescription drugs if the plan already covers them.¹²⁷ While non-exhaustive lists were used in other portions of the Parity Act, subsection (b) remained ambiguous.¹²⁸ To resolve this ambiguity, the Ninth Circuit looked to the Parity Act's enforcing regulation,

124. *See id.* at 712–16 (analyzing whether Parity Act alone compelled Blue Shield to provide coverage for Harlick). For a discussion of the Ninth Circuit's reasoning regarding whether the Parity Act requires coverage of residential treatment, see *infra* notes 127–31 and accompanying text.

125. *See Harlick*, 686 F.3d at 714–19 (examining Parity Act). For a discussion of the Ninth Circuit's reasoning in deciding whether the Parity Act requires insurers to provide all medically necessary treatment for anorexia, see *infra* notes 132–44 and accompanying text.

126. *See Harlick*, 686 F.3d at 719–21 (considering whether residential care was medically necessary). Although Blue Shield did not dispute the medical necessity of Harlick's treatment during her administrative appeals process, the company argued that, "it should be allowed to reopen its administrative process in order to determine whether Harlick's residential care was medically necessary." *Id.* at 719. The Ninth Circuit rejected this argument, stating that the rule "in this circuit and in others, is that a court will not allow an ERISA plan administrator to assert a reason for denial of benefits that it had not given during the administrative process." *Id.* at 719–20. During Blue Shield's communications with Harlick and her mother, the insurance company never stated that they were denying coverage because it was not medically necessary; rather, the insurance company repeatedly stated that coverage was denied because Harlick's plan did not cover residential treatment. *See id.* at 720 (demonstrating that insurance company did not cite medical necessity as reason for Harlick's coverage denial). Because the insurance company did not preserve this issue for appeal, the Ninth Circuit held that "Blue Shield forfeited the ability to assert that defense" *Id.* at 721.

127. *See id.* at 711 (noting benefits Parity Act provides).

128. *See id.* at 712 (reasoning that subsection (b) remained ambiguous because of express and specific language in Parity Act's other provisions). Subsection (a) specifically outlined one limitation: coverage must be provided for "medically necessary treatment of severe mental illnesses." *Id.* at 711 (citing CAL. HEALTH & SAFETY CODE § 1374.72(a) (West 2003)). In addition, subsection (c) was "explicitly characterized as a non-exhaustive list" because it used the language "shall include, *but not be limited to*" *Id.* at 712 (emphasis added) (citing § 1374.72(c)). Compared to these other statutory provisions, subsection (b) remained ambiguous because it stated "shall include," but did not indicate whether the list of care facilities was exhaustive. *See id.* (citing § 1374.72(b)) (interpreting Parity Act as non-exhaustive).

which was promulgated by the DMHC in 2003.¹²⁹ The regulation states that:

The mental health services required for the diagnosis, and treatment of conditions set forth in Health and Safety Code section 1374.72 [the Parity Act] shall include, when medically necessary, all health care services required under the Act *including, but not limited to*, basic health care services within the meaning of Health and Safety Code sections 1345(b) [Knox-Keene Act] and 1367(i) [Knox-Keene Act], and section 1300.67 of Title 28 [relating to Knox-Keene Act].¹³⁰

The Ninth Circuit reasoned that the regulation's wording, "including, but not limited to" justified the court's holding that subsection (b)'s list of services was not exhaustive.¹³¹

2. *Does the Parity Act Require Coverage for All Medically Necessary Treatments of Anorexia?*

In the crux of its opinion, the Ninth Circuit furthered its holding by stating that the Parity Act obliges insurers to cover not only residential care, but all medical necessary treatments enumerated in the Parity Act.¹³² The Ninth Circuit reached its holding by rejecting Blue Shield's proposed three-pronged test to determine when a "medically necessary" treatment must be covered.¹³³ Blue Shield argued that a medically necessary treatment must be covered when the treatment: "(1) is a level of care specified in subsection (b) of the Parity Act"; (2) "is a 'basic health care service' pursuant to the Knox-Keene Act; or (3) "is an additional (non-mandated)

129. See *id.* ("[T]he California Department of Managed Health Care . . . promulgated a regulation implementing the Parity Act in 2003.").

130. *Id.* (citing CAL. CODE REGS. tit. 28, § 1300.74.72(a) (2003)) (first alteration in original). Although the regulation did not explicitly refer to the Parity Act or the Knox-Keene Act, the Ninth Circuit assumed "that the word 'Act' refers to the Knox-Keene Act." *Id.* at 714 (citing CAL. CODE REGS. tit. 28, § 1300.45(a)) (drawing on another regulation of same chapter indicating that "Act" meant Knox-Keene Act). The Knox-Keene Act of 1975 defined "basic health care services" as physician services, hospital inpatient services, diagnostic laboratory, therapeutic and radiologic care services, home health care, preventive health care, and emergency health care." See CAL. HEALTH & SAFETY CODE § 1345(b) (2003) (outlining what is included in basic health care services); see also *Harlick*, 686 F.3d at 712–13 (noting that regulation's wording of "including, but not limited to," suggested that subsection (b) was intended to be illustrative).

131. See *Harlick*, 686 F.3d at 712–13 (holding that Parity Act's required modalities of treatment expands beyond inpatient treatment, outpatient treatment, partial hospitalization, and prescription drugs).

132. See *id.* at 719 ("We conclude that the most reasonable interpretation of the Parity Act and its implementing regulation is that plans within the scope of the Act must provide coverage of all 'medically necessary treatment' for 'severe mental illnesses' under the same financial terms as those applied to physical illnesses.").

133. See *id.* at 713–16 (outlining and rejecting Blue Shield's test establishing when "medically necessary" treatment would be covered).

benefit that the plan has chosen to provide for the treatment of" physical and mental illnesses.¹³⁴

The Ninth Circuit relied heavily on the DMHC's administrative history in its rejection of Blue Shield's argument.¹³⁵ The court reiterated the regulation's wording of "including, but not limited to" to justify the inclusiveness of all medical treatments.¹³⁶ Next, the court cited the DMHC's "unambiguous[] reject[ion]" of a similar argument made by Blue Shield during the agency's notice-and-comment process leading up to the regulation's promulgation.¹³⁷ In that notice-and-comment process, the DMHC explicitly noted: "*it is sufficient to state that the plans must provide all medically necessary services. To the extent that certain services are medically necessary, then those services will be provided.*"¹³⁸

134. See *id.* at 713 (outlining Blue Shield's recommended three-prong inquiry). The court cited Blue Shield's brief, which argued that the Parity Act's implementing regulation was to be interpreted as stating: "mental health services required under the Parity Act 'shall include, when medically necessary, all health care services required under the [Knox-Keene] Act, including, but not limited to, *basic health care services* within the meaning of [the statutory provisions].'" *Id.* (alterations in original).

135. See *id.* at 717 (justifying court's reliance on DMHC's authority as state agency). In relying on the DMHC's intent in its interpretation of the Parity Act, the Ninth Circuit noted that California law permits deference to state agencies when "the subject matter of the statute is especially technical or complex, or if the agency is interpreting its own regulation." *Id.* (citing *Yamaha Corp. of Am. v. State Bd. of Equalization*, 960 P.2d 1031, 1037 (Cal. 1998)). Moreover, an agency's interpretation of their rule is most likely to be correct after a notice-and-comment process, which occurred in the promulgation of the Parity Act's regulation. See *id.* (deferring to agency interpretation of Parity Act). An agency's interpretation is equally credible when the agency has "maintained a consistent interpretation over time." *Id.*

136. See *id.* at 714 ("Blue Shield plays down the importance of the phrase 'including but not limited to' by italicizing the words preceding and following that phrase. But the phrase is critical."). For the text of Blue Shield's interpretation of the Parity Act's regulation, see *supra* note 134 and accompanying text.

137. See *Harlick*, 686 F.3d at 714 (explaining Blue Shield's argument and why DMHC rejected it).

138. *Id.* at 715. Though the Ninth Circuit relied heavily on the DMHC's administrative history in supporting its holding, Blue Shield argued that the agency had interpreted the regulation differently on at least three different occasions. See *id.* at 717 (analyzing DMHC's varying interpretations of Parity Act's regulation). First, Blue Shield cited a case "in which DMHC demurred to a complaint seeking coverage of a medically necessary treatment for autism" See *id.* (reviewing Blue Shield's claim that DMHC inconsistently interpreted Parity Act regulation). The court responded by asserting that "[p]ositions taken by an agency for purposes of litigation ordinarily receive little deference under California law." *Id.* (citing *Yamaha Corp.*, 960 P.2d at 1045). Second, Blue Shield cited a survey conducted by the DMHC, in which the agency called an insurance company's lack of residential coverage a "policy decision." *Id.* at 717. In response to that claim, the court reasoned that the "DMHC was conducting a survey of residential treatment coverage as part of a larger preliminary study of mental health parity. The study was not—and was not designed to be—an enforcement proceeding." *Id.* at 718. Lastly, Blue Shield cited a letter written by DMHC's counsel in response to a complaint from Harlick's mother. See *id.* (deciding whether DMHC consistently inter-

Additionally, the court drew on the language of the Parity Act and reasoned that because the California legislature previously enumerated a specific exception for plans that carried prescription drugs, the legislature would have created other exceptions limiting medically necessary treatments.¹³⁹ Finally, the Ninth Circuit asserted that the third prong of Blue Shield's proposed test "lack[ed] support in common sense" because there are "some medically necessary treatments for severe mental illness [that] have no analogue in treatments for physical illnesses."¹⁴⁰

The Ninth Circuit then turned to Blue Shield's contention that because the regulation's reference to the word "Act" was assumed to refer to the Knox-Keene Act, "coverage mandated by the Parity Act for severe mental illnesses [was] no greater than coverage mandated by the Knox-Keene Act for physical illnesses."¹⁴¹ The majority opinion rejected this argument and found that the Parity Act and the Knox-Keene Act "operate in fundamentally different ways."¹⁴² The court reasoned that "[b]ecause the Parity Act applies to severe mental illnesses, some of which are life-threatening, it makes sense that the Act requires insurers to cover all medically necessary treatments."¹⁴³ Conversely, because the Knox-Keene Act applies to all physical illnesses, "it makes equal sense" that the legislature would "not require insurers to cover all medically necessary treatments," but rather only basic health services.¹⁴⁴

preted its Parity Act regulation). The letter stated, "[a]s Castlewood is licensed as a residential treatment center, rather than an acute in-patient facility, Blue Shield is not obligated to provide coverage for this treatment." *Id.* The court rejected Blue Shield's contention that this letter shows that the Parity Act does not mandate coverage for residential treatment, and stated that "Blue Shield misunderstands the scope of the DMHC's review" as it was only intended to serve as an independent medical review. *Id.* An independent medical review, the court stated, "deals solely with the question whether treatment was medically necessary for a particular patient," not whether an insurance company can categorically deny a treatment. *Id.* (citing CAL. HEALTH & SAFETY CODE § 1374.30(b), (d) (West 2003)).

139. *See id.* at 715–16 (reasoning that presence of other explicit exceptions suggests that legislature would have made all subsections equally as explicit if exception was intended).

140. *Id.* at 716.

141. *See id.* at 714. Although the court agreed with Blue Shield's assumption that the regulation referred to the Knox-Keene Act, the court explicitly noted: "But it does not follow that the coverage for severe mental illnesses mandated by the Mental Health Parity Act is restricted to the coverage for physical illnesses mandated by the Knox-Keene Act." *Id.*

142. *Id.* at 716.

143. *Id.*

144. *Id.* Judge Smith opposed the majority's ruling, emphasizing that the original opinion's interpretation of the word "Act" in the regulation to mean "Parity Act," was the "lynchpin for our conclusion that the Parity Act was not limited by the provisions of the Knox-Keene Act." *Id.* at 721 (Smith, J., dissenting). Thus, he asserted that because the majority opinion had changed what "Act" the regulation was referring to, the holding should have also limited "medically necessary treatments" to those within the scope of the Knox-Keene Act. *Id.* Judge Smith offered both a statutory interpretation argument and a legislative history argument to sup-

V. THE FRAILTY OF THE LEGISLATIVE FRAMEWORK: CAN WE ACHIEVE
PARITY WITHOUT THE HELP OF THE COURTS?

The Ninth Circuit's ruling in *Harlick* has elicited positive feedback from public health professionals and eating disorder advocates alike.¹⁴⁵ The court's expansion of medically necessary treatment for anorexia has been trumpeted as the "landmark victory for those suffering from eating disorders."¹⁴⁶ Moreover, the *Harlick* holding carries implications for other mental illnesses included in the Parity Act.¹⁴⁷ The court broadly held that "Blue Shield 'shall provide coverage for the diagnosis and medically necessary treatment' of 'severe mental illnesses,' including anorexia nervosa, for plans coming within the scope of the Act."¹⁴⁸ Thus, the Ninth Circuit did not limit its holding to residential treatment for anorexia, but rather, interpreted the Parity Act as requiring coverage for all medically necessary treatment for the statute's enumerated mental illnesses.¹⁴⁹

port his dissent. See *id.* at 722–27 (disagreeing with majority opinion because of statutory interpretation and legislative history).

In his statutory interpretation argument, Judge Smith attacked the emphasis the majority placed on the words "including, but not limited to," in the Parity Act's implementing regulation. *Id.* at 724. He noted that California law on statutory interpretation has held that "while the phrase 'including, but not limited to,' is admittedly a 'phrase of enlargement,' this phrase is 'not a grant of carte blanche that permits all actions without restriction . . .'" *Id.* Moreover, Judge Smith reasoned that the regulation's reference to the Knox-Keene Act shortly after the phrase "suggests that other non-listed services would similarly be of the type required under the Knox-Keene Act," not the Parity Act. *Id.* at 725. Judge Smith further distinguished state case law cited by the majority opinion, including *Arce*. See *id.* at 725. He clarified that the scope of the court's analysis in *Arce* was limited to an "unequal provision of coverage compared to physical illnesses," rather than a discussion of whether the Parity Act requires all medically necessary treatment for severe mental illnesses. *Id.* at 726. In his second argument regarding the Parity Act's legislative history, Judge Smith took note of the "elusive" history associated with the law and argued that the majority opinion's reliance on legislative history "results in the proverbial situation where the majority is 'looking over a crowd and picking out its friends.'" *Id.* (quoting *People v. Seneca Ins. Co.*, 62 P.3d 81, 86 (Cal. 2003)).

145. See Pollack, *supra* note 8, at 1 (reporting on public and stakeholder reactions to *Harlick* holding). For a discussion of stakeholder reactions to the Ninth Circuit's ruling, see *infra* notes 146–54 and accompanying text.

146. Colliver, *supra* note 13.

147. See *Harlick*, 686 F.3d at 721 ("California's Mental Health Parity Act provides that Blue Shield 'shall provide coverage for the diagnosis and medically necessary treatment' of 'severe mental illnesses,' including anorexia nervosa, for plans coming within the scope of the Act."); see also *Parity Act Requires "Medically Necessary" Coverage*, *supra* note 76 ("The *Harlick* opinion will compel insurers to conduct medical necessity reviews of proposed treatments for a broad range of mental health conditions.").

148. *Harlick*, 686 F.3d at 721.

149. See *id.* (holding that Parity Act covers diagnosis and all medically necessary treatment of "severe mental illnesses"); see also *Parity Act Requires "Medically Necessary" Coverage*, *supra* note 76 ("In addition to anorexia nervosa, subsection (d) of the Parity Act specifies that severe mental illness includes schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depres-

A. *Public Reaction to the Ninth Circuit's Holding*

The Ninth Circuit's broad holding has led to a divisive debate on the merits of mental health parity legislation, as well as a court's ability to enforce parity if insurers had previously not covered such medically necessary treatments.¹⁵⁰ One health economist has supported parity measures, stating that, "[p]arity seeks a fair approach to allocating treatment resources, so that a patient is not disadvantaged simply because he or she had the misfortune of being struck by a mental illness."¹⁵¹ Conversely, some medical professionals have expressed hesitation towards the Ninth Circuit's ruling because of the limited efficacy of controlled treatments, like residential care.¹⁵² In terms of eating disorders, one doctor stated that the regimented treatment at residential care facilities often leads to relapse "because patients are often unable to deal with the reduced structure in their life following discharge."¹⁵³ Health policy experts have also noted that the *Harlick* ruling "opens a slippery slope that has no natural limit."¹⁵⁴

However, the *Harlick* holding should not be interpreted as opening the floodgates for mental health patients to receive unbridled access to health care.¹⁵⁵ Rather, the *Harlick* ruling is broad enough to permit greater access to care, while continuing to limit such care to what is medi-

sive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, and bulimia nervosa.").

150. See *Parity Act Requires "Medically Necessary" Coverage*, *supra* note 76 ("Harlick is not likely to be the last word on the scope of benefits mandated under the Parity Act."). For a discussion on expanding mental health parity legislation through the courts, see *infra* notes 158–74 and accompanying text.

151. Richard G. Frank, *Parity Is the Fair Approach*, N.Y. TIMES (Oct. 14, 2011), <http://www.nytimes.com/roomfordebate/2011/10/14/should-insurers-pay-for-eating-disorders/parity-is-the-fair-approach>.

152. See Sally Satel, *A Serious Medical Condition*, N.Y. TIMES (Oct. 15, 2011), <http://www.nytimes.com/roomfordebate/2011/10/14/should-insurers-pay-for-eating-disorders/anorexia-nervosa-is-a-serious-medical-condition> (arguing that residential care may not be most effective care for eating disorder patients "because patients are often unable to deal with the reduced structure in their life following discharge"). But see Pollack, *supra* note 8, at 1 ("[S]ome doctors . . . say that hospitalization, which insurers typically cover, might stabilize a patient and restore weight but does not generally treat the underlying psychological issues. Outpatient treatment . . . provide[s] counseling but not round the clock. Residential treatment, they say, occupies a vital niche between those two.").

153. See Satel, *supra* note 152 (explaining limited success of residential treatment center).

154. Michael D. Tanner, *Higher Premiums for Everyone*, N.Y. TIMES (Oct. 14, 2011), <http://www.nytimes.com/roomfordebate/2011/10/14/should-insurers-pay-for-eating-disorders/higher-premiums-for-everyone>.

155. See Pollack, *supra* note 8 ("While the ruling applies only to California's law, some experts think it will influence courts, state agencies and insurers elsewhere. 'You'll see it bleed over,' said Scott Petersen, a lawyer in Salt Lake City who often represents insurance companies in parity cases.").

cally necessary.¹⁵⁶ This ruling not only acknowledges the necessity of individualized care for mental health patients, but it also permits doctors to make decisions regarding their patient's medically necessary treatment without the concern that the patient's insurance company can deny the treatment.¹⁵⁷

B. *The Ninth Circuit's Framework as a Model for Future Parity Policies*

Unlike most court decisions regarding parity laws, the *Harlick* holding set forth a parity analysis that expanded beyond statutory interpretation.¹⁵⁸ The court offered a unique contribution to mental health parity analysis by furthering policies that were consistent with the DMHC's intent.¹⁵⁹ Moreover, the court tailored its analysis to the individualized needs of mental health treatment.¹⁶⁰ By employing this framework, the *Harlick* case demonstrated that in order to achieve true parity, legislators and insurance companies must realize that "[s]ome medically necessary treatments for severe mental illness have no analogue in treatments for physical illnesses."¹⁶¹

In its ruling, the Ninth Circuit has held that all California insurers within the scope of the Parity Act must cover all medically necessary treatment for schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive compulsive disorder, autism,

156. See *Harlick v. Blue Shield of Cal.*, 686 F.3d 699, 721 (9th Cir. 2012) (holding that Blue Shield was required to cover diagnosis and medically necessary treatment of severe mental illness within scope of Parity Act).

157. See Colliver, *supra* note 13 (explaining how insurance companies dictate care). Colliver interviewed Dr. Neal Anzai, medical director of the eating disorders program at Alta Bates Summit Medical Center in Berkeley, who stated that "his patients have to be 'literally on the verge of death' to get hospitalized and then their insurance coverage often dictates how much care or what kind of care comes next." *Id.*

158. See *Harlick*, 686 F.3d at 721–25 (Smith, J., dissenting) (analyzing lower federal courts' statutory interpretation of Parity Act).

159. See *id.* at 717 (majority opinion) (justifying its deference to DMHC by noting that "an agency's interpretation is more likely to be correct when the interpretation has gone through formal notice-and-comment rulemaking, when there are 'indications of careful consideration by senior agency officials,' or when the agency has maintained a consistent interpretation over time"). Here, the Ninth Circuit cited the DMHC's formal notice-and-comment process leading up to the promulgation of the Parity Act's regulation. See *id.* at 714–15 (reviewing administrative history before promulgation of Parity Act regulation). In this notice-and-comment process, the DMHC explicitly rejected Blue Shield's interpretation of subsection (b) as exhaustive. See *id.* at 715 (deferring to agency interpretation of Parity Act).

160. See *id.* at 716 (noting that some treatments for mental health illnesses "have no analogue in treatments" for physical illnesses). For a discussion of the individualistic needs associated with mental health care, see *infra* notes 162–68 and accompanying text.

161. *Harlick*, 686 F.3d at 716 (emphasizing distinction between physical and mental illnesses).

anorexia, and bulimia.¹⁶² This holding is consistent with what the mental health community already knows: parity laws that only require equality in certain modalities of treatment, like inpatient and outpatient visits, frustrate the clinical community's understanding that physical and mental illness often require different treatment.¹⁶³ Perhaps the largest difference between physical and mental health care is the individualized care that most mental health patients need.¹⁶⁴ For example, while prescription drugs may alleviate symptoms of mental illnesses, mental health professionals recommend a combination of prescriptions with "psychosocial treatments and support."¹⁶⁵ These psychosocial treatments should be individualized, as the American Psychological Association recommends mental health physicians to "adapt or tailor psychotherapy to those specific patient characteristics in ways found to be demonstrably and probably effective."¹⁶⁶ This combined treatment of prescription drugs and individual therapy significantly reduces symptoms and improves the quality of life for seventy to ninety percent of mental health patients.¹⁶⁷ With the Ninth Circuit's ruling, this combined treatment is now possible for those insured under California health plans.¹⁶⁸

Further, the Ninth Circuit's ruling provides a solution to the criticism that legislation is insufficient to solve the inequities in insurance coverage.¹⁶⁹ Although recent legislation like the Affordable Care Act has

162. See *id.* (concluding that Parity Act required insurance companies to cover all medically necessary treatment for enumerated severe mental illnesses).

163. See Gardner, *supra* note 35, at 687 (noting that "psychopharmacological treatment of severe mental illness is rarely an ultimate cure").

164. See NAT'L UNION OF HEALTHCARE WORKERS, CARE DELAYED, CARE DENIED: KAISER PERMANENTE'S FAILURE TO PROVIDE TIMELY AND APPROPRIATE MENTAL HEALTH SERVICES 11 (2011), available at http://www.nuhw.org/storage/mental_health/CareDelayedCareDenied.pdf [hereinafter NUHW REPORT] (citing study by American Psychiatric Association, which recommends individual therapy for mental health patients).

165. See *What Is Mental Illness: Mental Illness Facts*, NAT'L ALLIANCE ON MENTAL ILLNESS, http://www.nami.org/template.cfm?section=about_mental_illness (last visited Feb. 21, 2013) (explaining doctor recommendations for mental illnesses).

166. See NUHW REPORT, *supra* note 164, at 15.

167. See *id.* (discussing different therapies that aid in mental health recovery); see also Gardner, *supra* note 35, at 687 (enumerating recovery rates for several mental illnesses). Once an individual with a mental illness can receive medically necessary treatment, the elimination of symptoms can often be extremely successful. See *id.* (explaining efficacy of pharmaceutical and therapeutic treatment for mental health patients). Gardner notes that whereas the success rate for heart disease is around forty-five percent, the success rates for mental illnesses are as follows: sixty-percent for schizophrenic patients; eighty to ninety percent for bipolar patients; seventy to ninety percent for panic disorder patients; seventy five percent for obsessive compulsive patients; and seventy to eighty percent for depressed patients. See *id.*

168. See, e.g., *Parity Act Requires "Medically Necessary" Coverage*, *supra* note 76 (discussing Ninth Circuit's broad holding).

169. See Kaplan, *supra* note 33, at 359 (asserting that "[m]ental health parity may not be an issue that can be solved with legislation").

moved closer toward achieving mental health parity on the federal level, its mandating power remains limited.¹⁷⁰ The Affordable Care Act, when read together with the MHPAEA, requires insurers to provide parity for mental health, substance abuse, and behavioral health services.¹⁷¹ Although the Affordable Care Act does not preempt state parity laws, the federal legislation only establishes a minimal set of mandatory coverage.¹⁷²

With insurance companies' reluctance to comply with state parity laws, as well as the weak mandating power of federal parity legislation, the courts have given mental health patients a stronger voice by enforcing state parity laws.¹⁷³ Outside of California, judicial action has been effective in New Jersey, where a settlement between Aetna Insurance and its beneficiaries resulted in the enforcement of a new policy which requires Aetna to provide coverage for eating disorders in the same manner as other covered mental illnesses.¹⁷⁴

170. See Tovino, *supra* note 20, at 40–45 (discussing ACA's implications for mental health parity); see also Shamash, *supra* note 27, at 309–15 (discussing impact of ACA on federal parity laws). Though the ACA contains provisions that “expand both mental health parity law and mandatory mental health and substance use disorder benefits,” this expansion is limited by an ACA provision that exempts health plans that were in effect before March 23, 2010. See Tovino, *supra* note 20, at 40–42 (explaining ACA's significant limitations on health benefit expansions). Only non-grandfathered health plans, or those that were established after March 23, 2010, are required to offer essential health benefits. See *id.*

171. See Shamash, *supra* note 27, at 318 (analyzing cumulative effect of ACA on federal mental health parity law).

172. See *id.* (acknowledging limitations to ACA's scope in context of mental health parity).

173. See, e.g., *Harlick v. Blue Shield of Cal.*, 686 F.3d 699, 721 (9th Cir. 2012) (holding that Parity Act required insurance companies to cover medically necessary treatment for severe mental illnesses); *Burton v. Blue Shield of Cal. Life & Health Ins. Co.*, No. CV 10–09581, 2012 WL 242841, at *5 (C.D. Cal. Jan. 12, 2012) (holding that despite plan's exclusion of residential care, plaintiff was entitled to residential treatment pursuant to *Harlick* holding).

174. See *DeVito v. Aetna, Inc.*, 536 F. Supp. 2d 523, 534 (D.N.J. 2008) (denying motion to dismiss, which challenged denial of benefits for eating disorder). In *DeVito*, both plaintiffs were the parents of daughters who suffered from eating disorders. See *id.* at 525 (explaining plaintiffs' histories with eating disorders). One plaintiff was denied treatment after Aetna informed the family that the treatment was not medically necessary. See *id.* Conversely, the other plaintiff was able to receive treatment, but was later denied coverage after the treatment “exceeded the contractual limitations for coverage of non-Biological Based Mental Illnesses.” *Id.* The district court denied Aetna's motion for dismissal. *Id.* at 534. In June 2008, Aetna made a \$250,000 settlement, agreeing to reimburse one hundred New Jersey policyholders who were denied coverage related to the diagnosis and treatment of eating disorders. See McGow, *supra* note 36, at 597 (discussing Aetna's settlement and its implications for increasing access to medically necessary care for eating disorders). Courts in New Jersey have enforced similar policies among Aetna's competitor insurance companies, such as Horizon and Amerihealth. See Pollack, *supra* note 8 (discussing impact of courts' holdings on parity laws outside of California).

VI. THE PROGNOSIS FOR *HARLICK*: TOTAL PARITY OR
FURTHER COMPLICATIONS?

In 2010, Laura Burton's husband contacted Blue Shield hoping to find "approved treatment facilities" for his wife, who had been suffering from depression and alcohol abuse.¹⁷⁵ Unable to receive specific information about approved residential treatment facilities from the insurance company, Laura Burton was admitted to Cottonwood Tucson inpatient mental health facility.¹⁷⁶ Upon admission, Laura was diagnosed with "alcohol dependence; major depressive disorder; posttraumatic stress disorder; panic disorder with agoraphobia; nicotine dependence; [and] sedative-hypnotic dependence."¹⁷⁷ Two months later, Blue Shield denied coverage for Laura's stay at Cottonwood Tucson.¹⁷⁸ Laura appealed the denial of coverage twice, and was denied both times.¹⁷⁹ In its denials, Blue Shield argued that the Burtons' plan did not cover residential treatment.¹⁸⁰ The insurer also claimed that substance abuse treatment was only covered insofar as such treatment was used "'to treat potentially life threatening symptoms of acute toxicity or acute withdrawal when [the patient is] admitted through the emergency room.'"¹⁸¹ Such life threatening symptoms, Blue Shield asserted, were not present in the case of Laura Burton.¹⁸²

Prior to *Harlick*, Laura Burton would have had little legal recourse after Blue Shield's internal reviews of her claim.¹⁸³ However, when Bur-

175. See *Burton*, 2012 WL 242841, at *2.

176. See *id.* (describing plaintiff's treatment at residential facility).

177. *Id.*

178. See *id.* at *3 (explaining plaintiff's communications with Blue Shield).

179. See *id.* (discussing Blue Shield's denial of plaintiff's stay at residential treatment facility).

180. See *id.* (noting Blue Shield's reasoning for denial of care).

181. *Id.* (alteration in original) (quoting Plaintiff's insurance plan).

182. See *id.* at *4 ("Although the records indicate that Plaintiff received treatment for alcohol withdrawal symptoms, there is no indication that she entered Cottonwood Tucson as part of any sort of emergency detoxification program.").

183. See *Jennifer A. v. United Healthcare Ins. Co.*, No. CV 11-01813, 2012 WL 3996877, at *1 (C.D. Cal., Sept. 11, 2012) (holding that, without Parity Act claim, denial of plaintiff's residential treatment was not abuse of discretion under ERISA). In *Jennifer A.*, the plaintiff had "a long history of the eating disorder anorexia nervosa." *Id.* at *3. After receiving treatment for her anorexia in a partial hospitalization program, Jennifer's insurance company authorized coverage for residential treatment. See *id.* at *4 (outlining treatment timeframe). The insurance company stopped its authorization of plaintiff's residential treatment, despite doctors' observations that Jennifer had "anxiety around food [and was] resistant to [calorie] increase." *Id.* at *5 (alterations in original). The insurance company justified its rejection for residential treatment by noting that plaintiff could receive equal treatment through partial hospitalization. See *id.* The plaintiff did not bring suit under the Parity Act, but rather only challenged the denial of benefits pursuant to ERISA. See *id.* at *8 n.11 ("Plaintiff does not challenge the denial of benefits under California law, for example, under the [Parity Act]."). Rather, the court applied an ERISA abuse of discretion analysis with a "low level of skepticism." *Id.* at *10. For an explanation of the Ninth Circuit's abuse of discretion analysis that the *Jen-*

ton sued Blue Shield in January 2012, the district court cited to the initial *Harlick* ruling, noting that the Parity Act “may require coverage of treatment that is not within the scope of an actual plan.”¹⁸⁴ The court reasoned that because two of Burton’s diagnosed illnesses were enumerated in the Parity Act and her treatment at Cottonwood was “at least in part, treatment for a severe mental illness,” the treatment fell within the scope of the Parity Act and Blue Shield was required to cover Laura’s treatment.¹⁸⁵

As seen in *Burton v. Blue Shield of California Life and Health Insurance Co.*,¹⁸⁶ *Harlick* has already begun to change the legal landscape of mental health parity by expanding access to care for mental health patients.¹⁸⁷ The *Burton* court’s holding suggests that lower federal courts are willing to apply the Ninth Circuit’s *Harlick* holding.¹⁸⁸ While the *Harlick* precedent bodes well for all mental health patients in terms of expanding access to care, an important question remains.¹⁸⁹ In applying the Parity Act to all medically necessary treatments for severe mental illnesses, as *Harlick* requires, who decides what constitutes medically necessary treatment?¹⁹⁰

nifer court applied, see *supra* note 123. The court held that, based on the “reasonableness of [the reviewing doctor’s] judgment,” the denial of plaintiff’s benefits was not an abuse of discretion. *Id.* at *12; see also Brunalli, *supra* note 30, at 598 (explaining courts’ involvement in insurance company’s denial of benefits for plaintiff). Without a state parity claim, as Brunalli explains, “litigation is premised on the ERISA’s cause of action for the improper denial of benefits under the terms of an employee benefit plan.” *Id.*

184. *Burton*, 2012 WL 242841, at *4.

185. See *id.* (explaining reasoning behind decision that there was no abuse of discretion).

186. No. 10-09581, 2012 WL 242841 (C.D. Cal. Jan. 12, 2012).

187. See Gary Pancer, *Ninth Circuit Decision Rules That Residential Treatment for Anorexia Nervosa Is Covered Under State Mental Health Parity*, HEALTHCARE LAW NEWSL. (Sedgwick Law L.L.P., L.A., Cal.), Sept. 2011, available at <http://www.sdma.com/ninth-circuit-decision-rules-that-residential-treatment-for-anorexia-nervosa-is-covered-under-state-mental-health-parity-09-07-2011/> (explaining how Ninth Circuit holding fits into Parity Act jurisprudence).

188. See *Burton*, 2012 WL 242841, at *5 (“The Ninth Circuit interpreted the Act to require that insurance companies provide coverage under the same financial terms and conditions for medically necessary treatment of ‘severe mental illnesses’ and medical conditions.”).

189. See *Harlick v. Blue Shield of Cal.*, 686 F.3d 699, 721 (9th Cir. 2012) (“[I]t appears that inpatient residential treatment was indeed necessary. But we need not decide that question.”). The court noted that because Blue Shield did not bring the issue up during the administrative process, it had “forfeited the ability to assert that defense,” and thus the court did not have to determine whether the treatment was medically necessary. See *id.*

190. See *id.* at 719–21 (discussing medical necessity in *Harlick*’s case). For a summary of the Ninth Circuit’s medical necessity analysis, see *supra* notes 133–38 and accompanying text. In its reasoning, the Ninth Circuit initially noted that “Blue Shield, as the plan administrator, normally makes the medical necessity determination in the first instance.” *Harlick*, 686 F.3d at 719 (emphasis added) (citing *Sarchett v. Blue Shield of Cal.*, 729 P.2d 267, 272–73 (1987)). Despite the majority’s assertion that they “need not decide” the question of medical necessity, the court nevertheless looked to *Harlick*’s doctors’ recommended treatments and con-

In order for mental health patients to receive lifesaving treatment, courts should defer to the plaintiff's doctors in determining whether a treatment is medically necessary.¹⁹¹ Deference to physicians promotes Parity Act compliance, as it prevents insurance companies from limiting coverage.¹⁹² Moreover, deference to the mental health clinical community is a continuation of the Ninth Circuit's rationale, and a long-awaited change to parity analysis.¹⁹³ For patients like Anna Westin, such change did not come soon enough.¹⁹⁴ But for patients like Jeanene Harlick and Laura Burton, the Ninth Circuit's holding reaffirms a mental health patient's need for individualized treatment, and provides a cure for the chronic discrimination that these patients have faced in the courtroom, and in society.¹⁹⁵

cluded that, "it appears that inpatient residential treatment was indeed necessary." *Harlick*, 686 F.3d at 721. Though the *Harlick* court initially suggested that the medical necessity inquiry should be reserved for the ERISA plan administrator, the majority opinion's deference to *Harlick*'s doctors suggests that a court, when viewing the record, can draw inferences of medical necessity depending on the doctor's recommended treatment. *See id.* ("Given that *Harlick*'s doctors believed that outpatient treatment was insufficient, that *Harlick* entered Castlewood at 65% of her ideal body weight, and that *Harlick* needed a feeding tube while at Castlewood, it appears that inpatient residential treatment was indeed necessary."). *Id.* at 721.

191. *See id.*

192. *See* Brunalli, *supra* note 30, at 594 (explaining that most insurance companies took advantage of minimal state and federal regulation of insurance plans to "reduce health care costs" by "using health insurance policies with greater restrictions and limitations on mental illnesses").

193. *See* Colliver, *supra* note 13 (interviewing *Harlick*'s attorneys, who stated that *Harlick*'s story illustrates "the discrimination insurance companies put on mental illnesses and the very little understanding they have about eating disorders").

194. *See* Westin, *supra* note 2 (recounting Anna Westin's history with anorexia and her subsequent suicide). For a further discussion of Anna Westin's story, see *supra* notes 2–7 and accompanying text.

195. *See Harlick*, 686 F.3d at 716 (stating that Blue Shield's argument "lacks support in common sense" because "it makes no sense in a case such as *Harlick*'s to pay for time in a Skilled Nursing Facility—which cannot effectively treat her anorexia nervosa—but not to pay for time in a residential treatment facility that specializes in treating eating disorders"); *see also* NUHW REPORT, *supra* note 164, at 15 (stating that psychotherapy for mental health patients must "adapt or tailor . . . those specific patient characteristics in ways found to be demonstrably and probably effective" (quoting John C. Norcross & Bruce E. Wampold, *Evidence-Based Therapy Relationships: Research Conclusions and Clinical Practices*, 48 PSYCHOTHERAPY 98 (2011))).